

medium into the inferior vena cava or hepatic veins (IVC) on CTPA is a simple sign that could help for PE risk stratification. The purpose of this study was therefore to investigate prognosis significance of contrast reflux into IVC in acute PE.

Methods and Results: 141 consecutive patients with acute PE confirmed by CTPA were prospectively included between March 2010 and February 2013. Degree of reflux into the IVC and the hepatic veins was graded from 1 (none) to 6 (severe) by 2 independent observers, blinded to each other. The presence of reflux in IVC was compared with clinical parameters used in the ESC guidelines for PE risk stratification: electrocardiographic signs, Troponin I, BNP and right ventricular dilatation (RV/LV>0.9) or dysfunction (TAPSE < 17mm, S'<10cm/s) by echocardiography. Composite endpoint was 30-days mortality or clinical deterioration requiring treatment escalation (catecholamine infusion, thrombolytic treatment or cardiopulmonary resuscitation). The composite end-point was observed in 5% of patients with a 30-day mortality rate of 2.1%. Heart rate >110 bpm (OR 5.6, 1.03-30), atrial fibrillation (OR 6.3, 1.05-37.7), negative anterior T waves (OR 6.1, 1.3-29.1), elevated Troponin Ic (OR 5.4, 1.1-25.8), elevated BNP (OR 11.5, 1.3-98.2), right ventricular dysfunction (OR 5.3, 1.1-25.1) were predictors of death or clinical deterioration. Contrast reflux into IVC from grade 4 to 6 was observed in 17% of patients. Inter-observer agreement was excellent (Concordance correlation coefficient 0.91). Grade 4 reflux or greater was a strong predictor of events (OR 15.1, 2.8-83.7) and had a 86% specificity and 71% sensitivity to predict adverse outcomes (AUC 0.88).

Conclusion: A grade 4 or higher contrast reflux into the IVC is a simple and frequent CTPA sign, highly predictive of adverse outcomes in PE patients.

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Prehospital management of STEMI at the university hospital of Reims: are delays in adequacy with recommendations?

Sarah Ledon (1), Benoit Hercé (1), Pierre Willem (2), Yannick Lepers (1), Pierre Nazeyrollas (1), Damien Metz (1)
(1) CHU Reims, Cardiologie, Reims, France – (2) CH Chalons-en-Champagne, Urgences-SMUR, Chalons-En-Champagne, France

Introduction: the prognosis of STEMI is associated with the delay between the symptoms onset and the reperfusion. Recent recommendations regarding patient care differ widely according to the estimation of this delay, which should depend of the distance between first medical contact and PCI capable center. Our study aimed to appreciate the timing of prehospital and hospital management of STEMI in our settings.

Methods: We included prospectively between october 2013 and february 2014 incoming patients with acute STEMI and recorded the timings of the onset of symptoms, first medical contact, therapeutic decision, (thrombolysis or primary PCI), arrival in PCI-capable center and revascularization. Distance between first medical contact and the PCI unit was classified as none (emergency room), zone 1 (same town), zone 2 (under 30km), zone 3 (30 to 100km) and zone 4 (over 100km).

Results: Forty-seven patients were included, 82% men, average age 61±12.2 years. Delay from symptoms onset and first medical contact was 120±123 min (range: 2-585), less than 2 hours for 75% of the patients, and was 2h longer when patients came by themselves to the emergency department. Delay between medical contact and decision averaged 33 min (1 to 110min), thrombolysis was performed in 16 patients, 6 of which less than 30min after contact. The average door-to-balloon delay was 162±12 min. The transfer delay was 127±74 min and was associated with the distance between the first contact location and the PCI center. The difference between the effective delay, and the theoretical travel time ranged from 50 min in zone 1 to 150min in zone 4, increasing with the distance, mostly because of waiting for transportation in the emergency room.

Conclusion: The delay between first medical contact and effective arrival in our PCI capable center was always much longer than could be expected from the distance, thus displaying that the recent European recommendations have yet to be explained and enforced.

0118

Takotsubo cardiomyopathy following acute cerebral events

Christelle Blanc (1), Marianne Zeller (2), Yannick Bejot (1), Benoit Daubail (1), Anne-Laure Vialatte (1), Yves Cottin (3), Maurice Giroud (1)
(1) CHU Dijon, Neurologie, Dijon, France – (2) Faculté de Médecine, INSERM U866, LPPCM, Dijon, France – (3) CHU Dijon, Hôpital Bodge, Cardiologie, Dijon, France

Objective: Takotsubo cardiomyopathy is characterized by a transient apical ventricular dysfunction typically induced by an acute stress. Acute cerebral events including ischemic stroke (IS) or Epileptic Event (EE) may both be associated with massive catecholamine release. We aimed to identify the characteristics and outcomes of patients who experienced Takotsubo syndrome complicating an IS or EE.

Methods: Between 2008 and 2013, 87 patients were admitted in our Intensive Care Unit for suspected Takotsubo syndrome, of whom 6 previously experienced acute cerebral symptoms with either IS or EE, within two days. Takotsubo syndrome was diagnosed on Cardiac Magnetic Resonance, echocardiographic, electrocardiographic, biological and coronary angiography data.

Results: Five women and one man were included. The mean age was 63.7±20.1 years old (range: 44-84). Four of them (67%) presented initially an acute IS and two (33%) had EE. The suspected culprit brain injury was the insular cortex for three patients or posterior fossa for two patients. Hemiparesis, aphasia and cerebellar symptoms were the main neurological signs. Abnormal ECG findings including ST segment elevation (33%) or T waves inversion (50%) developed between few hours and 48 hours after the onset of IS or EE. Troponin peak was at 1,8 (0.79-14,11) µg/L. A transient alteration of the left ventricular ejection fraction (46±12%) with apical hypokinesis was found at echocardiography. Two (33%) patients developed an acute heart failure. Coronary angiography confirmed the lack of significant coronary stenosis for all the patients.

Conclusion: Takotsubo cardiomyopathy can develop early within the first days after an acute cerebral event, predominantly in women with insular or posterior fossa lesions and induced by possible vegetative reactions.

0301

Pulmonary embolism mimicking acute coronary syndrome: How to make the right diagnosis? A case report and literature review

Sanaa Benhaourech, Ayoub El Hammiri, Rachida Habbal
CHU Ibn Rochd, Cardiologie, Casablanca, Maroc

Introduction: Clinical and electrocardiographic features in Pulmonary Embolism lack of specificity and may mimic an acute coronary syndrome.

Case presentation: We report a case of a 55-year-old man hypertensive and with history of active smoking, presenting with epigastric pain and polypnea, the Troponin was positive (12.51 ng/ml, normal values <0.06ng/ml) and at the ECG we found negative T waves in anterior territory initially diagnosed as Non-STEMI, the coronary angiography was normal, and the echocardiography found a major dilatation of right chambers (DTDRV / DTDLV >1) and pulmonary hypertension (45 mmHg), thoracic CT angiogram objectify a massive embolism of the right and left pulmonary arteries, which confirmed the diagnosis of intermediate risk pulmonary embolism and the treatment was adjusted, the patient was discharged under acenocoumarol.

Conclusion: We report through this clinical case a misdiagnosed pulmonary embolism treated as Non-STEMI, the clinical and electrocardiographic features may be confusing between this two emergencies, because of lack of specificity of the symptoms, the hypothesis of pulmonary embolism may be suspected by the echocardiography when aspect of acute Cor pulmonale is present and the confirmation should be obtained by thoracic CT angiogram.